TEXAS
Health and Human
Services Commission

DSRIP Statewide Learning Collaborative, Population Health

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Topics of Discussion

1. An overview of **population health** and its importance

2. A discussion of **DSRIP Statewide Analysis**

3. A highlight of other health outcome data available to stakeholders:

   - **DSRIP Category 4 Data**

   - **Texas Department of State Health Services, Center for Health Statistics- Texas Health Data System**

What is Population Health?

- There are various definitions of population health, but it was first defined in 2003 as the **health outcomes of a group of individuals**, **including the distribution of such outcomes within the group**.

- The different concepts of population health fall along a spectrum ranging from the focus on health outcomes in **populations defined** by **geography or similar factors**, to accountability for health outcomes in populations defined by **healthcare delivery systems**.

What is Population Health? Continued…

- The term population health describes both:
  - A **clinical perspective** focused on delivery of care to groups in a health system; and
  - A **broad perspective** focused on the health of all people in a geographic area and emphasizes multisector approaches and incorporation of nonclinical interventions to address social determinants of health.

What is Population Health? Continued…

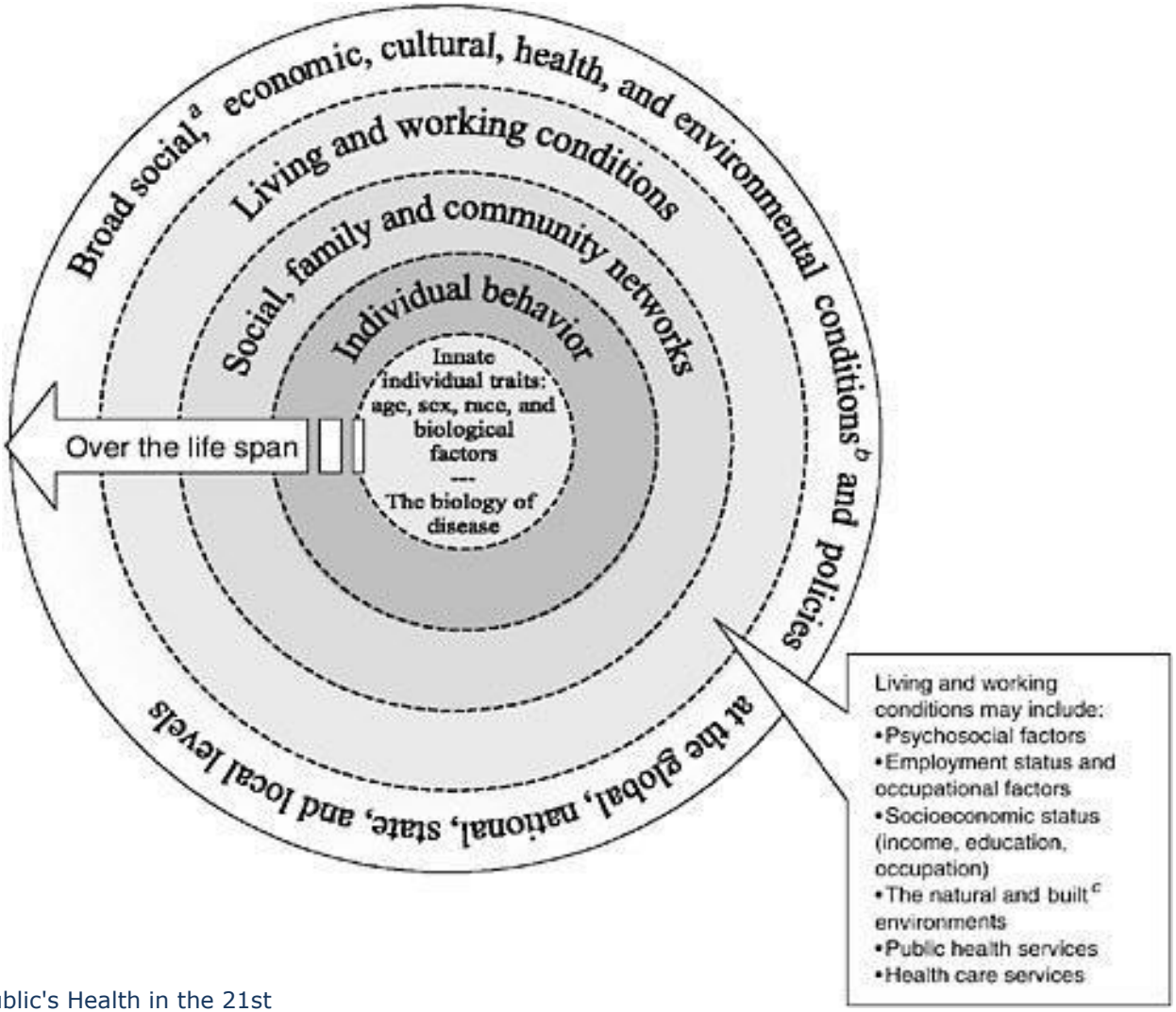
- Accountability for health outcomes in populations leads providers to address **upstream factors** such as health promotion and care coordination that influence health outcomes in "their" population.

- Population health requires the **consideration of** a broader array of the **determinants of health** and recognize that responsibility for population health outcomes is shared.

- To improve population health, communities must establish and nurture **partnerships** that include, but go beyond state and local public health agencies, local public health agencies and healthcare delivery systems.

- This broad system of partners must share data and adopt systems that identify **accountability** for the measure's contributions to population health outcomes.

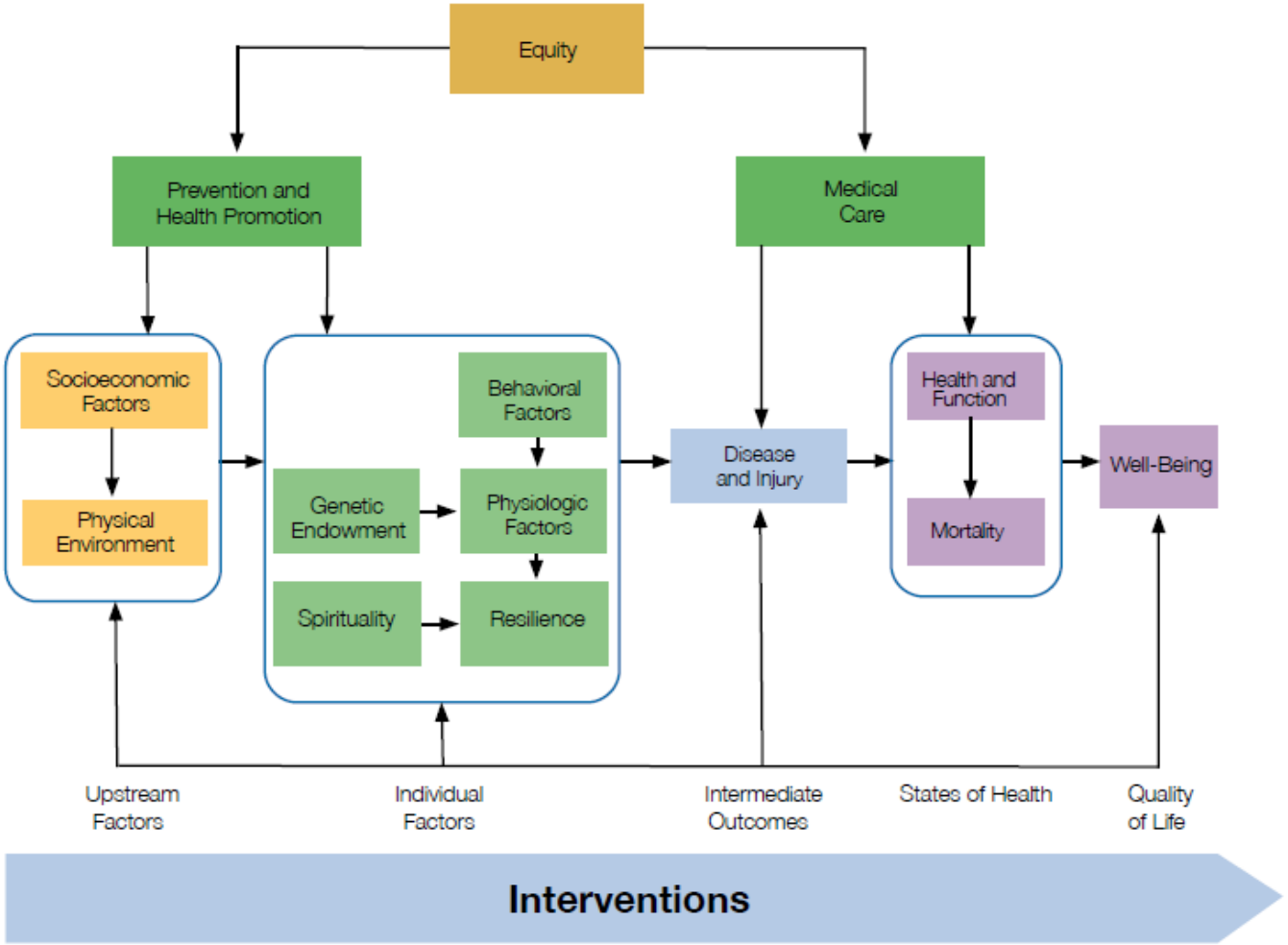
Socio-ecological Model



The Future of the Public's Health in the 21st Century, Institute of Medicine, 2003

Population Health Model

Figure 1. IHI Population Health Composite Model



Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

The Importance of a Common Set of Population Health Outcomes

- A common set of population health outcomes provides a portrait of a community's health. Data can help residents, community groups, and professional organizations **prioritize prevention activities** and **build coalitions to make improvements and address existing problems**.

- A **common set of population health outcomes** can **facilitate comparisons** across populations, promote collaboration between organizations conducting assessments, assist in establishing a shared understanding of the factors that influence health, and help to galvanize residents to **work collaboratively to improve community health**.

CMS Quality Strategy

- The mission of the CMS Quality Strategy focuses on:
  - Improving outcomes
  - Beneficiary/consumer experience of care
  - **Population health**
  - Reducing healthcare costs through improvement

DSRIP Statewide Analysis

- HHSC continues to work with ICHP to provide an ongoing analysis of **select health outcomes at the regional and state level**
- Selected measures includes available data that aligns with DSRIP projects or state priorities
- Data provided reflects Medicaid Managed Care data as well as some all-payor data
- Data may not always be reflective of the entire DSRIP population

DSRIP Statewide Analysis Plan

- The measures highlighted in DSRIP Statewide Analysis include:
  - **3M Potentially Preventable Event** Measures (PPA, PPC, PPR, PPV)
  - **AHRQ Adult and Pediatric Quality Indicators** (PQI and PDI) such as diabetes and hypertension admission rates
  - **Utilization of Care Measures** including outpatient and ED visits
  - **HEDIS** Measures related to **behavioral health**
  - **HEDIS** Measures related to **access to care measures** such as breast cancer screening & frequency of ongoing prenatal care

Other Statewide/RHP Data Available DSRIP Category 4

- The HHSC Transformation website also includes Calendar Year 2013 data (DSRIP and UC providers only) stratified by RHP for:
  - Potentially Preventable Admissions;
  - Potentially Preventable Readmissions; and
  - Potentially Preventable Complications.
- http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml

Accessing State and County Healthcare Outcome Data

- **The Texas Department of State Health Services, Center for Health Statistics**, provides a **Texas Health Data system**, which is an interactive public data system that allows you to query DSHS public health datasets for statistical reports and summaries.

  http://healthdata.dshs.texas.gov/Home

Texas Health Data
DSHS Center for Health Statistics

- Contains links to public data and statistics on various public health topics such as:
  - **Texas Health Facts Profiles** (county and regional profiles that include data such as **socioeconomic indicators** such as number of TANF recipients, births, deaths, demographics)
  - **Disease and Trauma Surveillance data** such as Texas injury statistics (ex: number of assault injuries by state, trauma service area, public health (PH) region or county)
  - **Healthcare Utilization & Quality data**, such as number of inpatient hospitalizations by payor source filtered by state, county, metro area or PH region
  - **Health Risks and Preventions** such as percentage of adults categorized as overweight or obese based on self-reported body mass index (BMI) (Texas Behavioral Risk Factor Surveillance System)
- Database includes links to data sources and methodologies

Conclusion

- **Population Health** looks at **health outcomes of a group** of individuals, including the **distribution of such outcomes** within the group.
- The **"population"** assessed can be defined by geography, health systems or other similar factors.
- Population Health has been used to describe both a **clinical** perspective of health and a **broader** perspective of health that focuses on the social determinants of health.
- A **common set of population health outcomes** can:
  - **facilitate comparisons** across populations,
  - promote **collaboration** between organizations
  - assist in considering **factors that influence health**, and
  - Promotes individuals/groups to **work collaboratively to improve community health**.